

Kerrville I.S.D. Early Childhood Center

Head Start

1011 Third Street ~ Kerrville, TX 78028

(830) 257-1335 (830) 257-7885 fax

Physical Exam Form

Child's Name: _____ DOB: _____

Are you the primary health care provider for this child? Yes No

Is this the first time you have seen this child? Yes No

Will you continue to be the child's primary health care provider? Yes No

HEALTH HISTORY:

ANY ROUTINE MEDICATIONS?: If yes, what medication, dose, duration.

Date of most recent well child physical exam: _____

SCREENING TESTS: The following are **required** by Head Start

Present Age: _____ HEMATOCRIT OR

HEIGHT: _____ HEMOGLOBIN: _____

WEIGHT: _____ LEAD LEVEL: _____

Vision Yes No Type of Test: _____ Results: _____

Hearing Yes No Type of Test: _____ Results: _____

Speech Yes No Type of Test: _____ Results: _____

Is this child up-to-date on a schedule of well child health care: Yes No

If no, what does this child need?: _____

GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

PRINT - Provider's Name

Office Telephone Number

Signature of Primary Health Care Provider

Date